

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

10227

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural | | c. LENGTH OF STAY IN 1b 20 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant View - Adamstown Rt. 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Arthur Last Ambush | | 4. DATE OF DEATH Month 9 Day 16 Year 19 59 | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 4 - 1882 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmers helper | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Patrick H. Ambush | | 14. MOTHER'S MAIDEN NAME Henrietta Coats | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-18-7720 | |
| 17. INFORMANT Laura V. Ambush | | Address Adamstown Rt. 1-Fred. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 9 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-14 , 19 59 , to 9-16 , 19 59 , that I last saw the deceased alive on 9-14 , 19 59 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 W. All Saints St. Fred. Md. DATE SIGNED 9-18-59 | | | |
| ACTUAL SIGNATURE U. G. Bourne M.D. | | | |
| PHYSICIAN'S NAME (Type) U. G. Bourne | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-19-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fairview | | 22d. LOCATION (City, town, or county) (State) Frederick, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III | | ADDRESS Frederick, Md. | |
| 24a. REC'D BY REGISTRAR DATE SEP 22 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur P. Harris | |

THE STATE OF TEXAS

10883

1

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10193

10209

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>Emmitsburg</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. Edna M. Asbaugh</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 7 1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-30-23</u> | |
| 9. AGE (In years last birthday) <u>36</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>ST. MARY'S College</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | |
| 13. FATHER'S NAME <u>MR. ERVIN BLACK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MRS. MARY M. Rudy</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis & uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the cervix uteri</u> DUE TO (c) <u>Carcinoma of the cervix uteri</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>59</u> , to <u>Sept 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>59</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas R. Reid, M.D.</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Sept 7, 1959</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Thomas R. Reid M.D.</u> | | | | M.D. <u>Medical Center, Frederick, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-10-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Kneass</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10210

CERTIFICATE OF DEATH

10194

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u> | | | | d. STREET ADDRESS <u>904 Seminole Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>Baer</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 2, 1959</u> | |
| 9. AGE (In years last birthday) yrs. <u>1</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | | IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Bernard Charles Baer</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Dorothy Louise Ridgeway</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT <u>Mother</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>2 Sept.</u> 19 <u>59</u> to <u>3 Sept.</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3 Sept.</u> 19 <u>59</u> , and that death occurred at <u>11:20</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4 Sept. 59</u> ACTUAL SIGNATURE <u>A. M. Powell Jr.</u> M.D. <u>Medical Center</u> PHYSICIAN'S NAME (Type) <u>A. M. Powell Jr. Md.</u> <u>Frederick, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Sept. 5, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Frederick, Maryland</u> | | | | (State) | | 24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | | | | 24c. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2269333XU0

10211

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | c. LENGTH OF STAY IN 1b <u>24 hrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | d. STREET ADDRESS <u>1904 Seminole Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>Girl</u> Last <u>Baer</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1959</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 3, 1959</u> |
| 9. AGE (In years last birthday) yrs. <u>1</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Bernard Charles Baer</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Louise Ridgeway</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>mother</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sclerema Neonatorum</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>2 Sept.</u> , 19 <u>59</u> , to <u>4 Sept.</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>4 Sept.</u> , 19 <u>59</u> , and that death occurred at <u>5:15</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A.M. Powell Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>Medical Center</u> | |
| PHYSICIAN'S NAME (Type) <u>A.M. Powell JR. Md.</u> | | DATE SIGNED <u>4/9/59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 5, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> |
| 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M.R. Etchison & Son</u> | | 24a. REC'D BY REGISTRAR <u>SEP 9 '59</u> | |
| ADDRESS <u>106 E. Church Street Frederick, Maryland</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

2169332XU1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10211

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED <i>John Doe</i></p> | | <p>2. SEX <i>Male</i></p> | |
| <p>3. AGE <i>45</i></p> | | <p>4. DATE OF BIRTH <i>Jan 15 1900</i></p> | |
| <p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p> | | <p>6. OCCUPATION <i>Teacher</i></p> | |
| <p>7. MARITAL STATUS <i>Married</i></p> | | <p>8. DATE OF MARRIAGE <i>June 10 1925</i></p> | |
| <p>9. NAME OF SPOUSE <i>Jane Doe</i></p> | | <p>10. DATE OF DEATH <i>Dec 10 1945</i></p> | |
| <p>11. PLACE OF DEATH <i>Home</i></p> | | <p>12. CAUSE OF DEATH <i>Heart Disease</i></p> | |
| <p>13. MEDICAL HISTORY <i>None</i></p> | | <p>14. PRESENT ILLNESS <i>None</i></p> | |
| <p>15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p> | | <p>16. SIGNATURE OF REGISTRAR <i>John Doe</i></p> | |
| <p>17. DATE OF SIGNATURE <i>Dec 10 1945</i></p> | | <p>18. PLACE OF SIGNATURE <i>Baltimore, Md.</i></p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10196

Reg. Dist. No.

10228

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lantz R D I</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lantz R D I</u> | | | |
| c. LENGTH OF STAY IN 1b <u>Life</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Archie Mead Burliman</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 5 1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 4, 1902</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Corn. Wheat. etc.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Frederick Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harvey M Burliman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Theresa H Reed</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>21244-6194</u> | | 17. INFORMANT <u>Mrs. Charlotte Burliman Lantz R D I</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>B. O. Thomas</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 5, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept. 8, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Bethel Methodist</u> | | 22d. LOCATION (City, town, or county) (State) <u>Nr. Garfield Fredk Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> | | | | ADDRESS <u>Thurmont MD</u> | | 24a. REC'D BY REGISTRAR <u>SEP 8 59</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hantz</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| NAME OF DECEASED _____ | | SEX <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| AGE _____ | | DATE OF BIRTH _____ | |
| PLACE OF BIRTH _____ | | DATE OF DEATH _____ | |
| OCCUPATION _____ | | CAUSE OF DEATH _____ | |
| MANNER OF DEATH _____ | | MEDICAL HISTORY _____ | |
| PRESENT ILLNESS _____ | | POST-MORTEM EXAMINATION _____ | |
| SIGNATURE OF MEDICAL EXAMINER _____ | | SIGNATURE OF CORONER _____ | |
| CITY OF BOSTON _____ | | COUNTY OF SUFFOLK _____ | |



RECEIVED
 BOSTON
 MAY 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10212

CERTIFICATE OF DEATH

10197

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CLEO Middle REGINA Last CANNON | | | | 4. DATE OF DEATH Month September Day 8, Year 19 59 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 Sept 1908 | | 9. AGE (In years last birthday) 50 yrs. | IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-working | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James R. Wynkoop | | | | 14. MOTHER'S MAIDEN NAME Mary B. Thomas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-01-7152 | | INFORMANT Address Garel C. Cannon, Sr. (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 gastrointestinal carcinoma of abdominal organ DUE TO (b) originating in colon. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 58 to Sept 8 , 19 59 , that I last saw the deceased alive on Sept 8 , 19 59 , and that death occurred at 7:05 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St. Frederick, Md. DATE SIGNED 10 Sept 1959 | | | | | | | |
| ACTUAL SIGNATURE H. F. Kline | | M.D. H. F. Kline, M. D. | | | | | |
| PHYSICIAN'S NAME (Type) H. F. Kline, M. D. | | Frederick, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-11-1959 | | 22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick County Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS Frederick, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 11 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

069

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CERTIFICATE OF DEATH

1935

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

CERTIFICATE OF DEATH

Reg. Dist. No.

10229

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE PENNA b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ijamsville | c. LENGTH OF STAY IN 1b 5 yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHILADELPHIA 75x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Carlton Last Carlton | | 4. DATE OF DEATH Month Sept Day 21 Year 59 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 22 1885 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months 14 Days 19 Hours 59 Min. | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | 11. BIRTHPLACE (State or foreign country) U S A |
| 13. FATHER'S NAME John L Jones | | 14. MOTHER'S MAIDEN NAME Willie Able | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ✓ | 17. INFORMANT MARY C. MACKESSON Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- |
| 20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from march 24 , 19 54 , to Sept 21 , 19 59 , that I last saw the deceased alive on sept 21 , 19 59 , and that death occurred at 5.15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Joseph Lerner M.D. Ijamsville Md Sept 21 59 | | | |
| ACTUAL SIGNATURE Joseph Lerner PHYSICIAN'S NAME (Type) Joseph Lerner | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF SEPT 23-59 | 22c. NAME OF CEMETERY OR CREMATORY BAKWOOD CEMETERY | 22d. LOCATION (City, town, or county) (State) STATESVILLE N.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falconer | | ADDRESS New Market Md | 24a. REC'D BY REGISTRAR SEP 30 '59 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur B. Hume | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10199

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#7 | | c. LENGTH OF STAY IN 1b Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Reciever Road | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First IRENE Middle BROWNE Last CUNNINGHAM | | 4. DATE OF DEATH Month September Day 9 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 7, 1895 |
| 9. AGE (In years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alexander S. Browne | | 14. MOTHER'S MAIDEN NAME Mary Jane Baughmann | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mrs. J.R. Jackson, Sewickley, Penna. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH minutes years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 9/9, 1955 to 9/9, 1959 that I last saw the deceased alive on 9/9, 1959 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James B. Thomas | | ADDRESS (Street, city or town, state) Professional Building, Frederick, Maryland | |
| PHYSICIAN'S NAME (Type) James B. Thomas, M. D. | | DATE SIGNED 9/11/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sepr. 22, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sewickley Cemetery | | 22d. LOCATION (City, town, or county) (State) Sewickley, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE SEP 14 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur G. Thomas | | | |

CERTIFICATE OF DEATH

10830

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Name of physician: [illegible]

6. Name of informant: [illegible]

7. Signature of informant: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Place of registration: [illegible]

12. Name of registrar: [illegible]

13. Signature of registrar: [illegible]

14. Date of registration: [illegible]

15. Place of registration: [illegible]

16. Name of registrar: [illegible]

17. Signature of registrar: [illegible]

18. Date of registration: [illegible]

19. Place of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10200

Reg. Dist. No.

| | | | | | | | | | | | | | | | |
|--|--|-------------------------------------|---------------------------------|--|--|--|---|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick 10231 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40 Nr. Frederick | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS 417 Durham St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Peter Densuk or Densuk | | | | 4. DATE OF DEATH Month Day Year September 24 1959 | | | | | | | | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 6, 1920 | | 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender | | | | 10b. KIND OF BUSINESS OR INDUSTRY Tavern | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME THEODORE DENSUK | | | | | | 14. MOTHER'S MAIDEN NAME ANNA BOYKO | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Eleanor G. Densuk 2405 N Calvert Street | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision Route 40 | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 9/24/59 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 | | | | 20f. (City or town) (County) (State) Nr. Frederick, Frederick Md. | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>B.O. Thomas</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) B.O. Thomas M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 25, 1959 | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF Sept 28 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Elkridge Md | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruffel Bro.</i> | | | | | | ADDRESS 1800 E Lombard Street | | | | 24a. REC'D BY REGISTRAR DATE SEP 29 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| PLACE OF DEATH County | | Residence | |
| A. ONE TO FIVE YEARS PREVIOUS TO DEATH | | B. SIX TO FIFTEEN YEARS PREVIOUS TO DEATH | |
| 1. NAME OF DECEASED | | 2. SEX | |
| 3. AGE | | 4. OCCUPATION | |
| 5. MARITAL STATUS | | 6. COLOR | |
| 7. BIRTH DATE | | 8. BIRTH PLACE | |
| 9. DATE OF DEATH | | 10. TIME OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | |
| 13. SIGNATURE OF EXAMINER | | 14. SIGNATURE OF WITNESS | |
| 15. SIGNATURE OF CORONER | | 16. SIGNATURE OF JURY | |
| 17. SIGNATURE OF MINISTER | | 18. SIGNATURE OF CHURCH | |
| 19. SIGNATURE OF FUNERAL HOME | | 20. SIGNATURE OF BURIAL PLACE | |
| 21. SIGNATURE OF CEMETERY | | 22. SIGNATURE OF INTERVIEW | |
| 23. SIGNATURE OF INTERVIEW | | 24. SIGNATURE OF INTERVIEW | |
| 25. SIGNATURE OF INTERVIEW | | 26. SIGNATURE OF INTERVIEW | |
| 27. SIGNATURE OF INTERVIEW | | 28. SIGNATURE OF INTERVIEW | |
| 29. SIGNATURE OF INTERVIEW | | 30. SIGNATURE OF INTERVIEW | |
| 31. SIGNATURE OF INTERVIEW | | 32. SIGNATURE OF INTERVIEW | |
| 33. SIGNATURE OF INTERVIEW | | 34. SIGNATURE OF INTERVIEW | |
| 35. SIGNATURE OF INTERVIEW | | 36. SIGNATURE OF INTERVIEW | |
| 37. SIGNATURE OF INTERVIEW | | 38. SIGNATURE OF INTERVIEW | |
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| 91. SIGNATURE OF INTERVIEW | | 92. SIGNATURE OF INTERVIEW | |
| 93. SIGNATURE OF INTERVIEW | | 94. SIGNATURE OF INTERVIEW | |
| 95. SIGNATURE OF INTERVIEW | | 96. SIGNATURE OF INTERVIEW | |
| 97. SIGNATURE OF INTERVIEW | | 98. SIGNATURE OF INTERVIEW | |
| 99. SIGNATURE OF INTERVIEW | | 100. SIGNATURE OF INTERVIEW | |

CERTIFICATE OF DEATH

Reg. Dist. No.

10213

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 220 Carroll Parkway | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last FOGLE | | | | 4. DATE OF DEATH Month September Day 29 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7 July 1884 | |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Wholesale Grocery | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME J. Edward Fogle | | | | 14. MOTHER'S MAIDEN NAME Virginia Flautt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 214-10-4442 | | | |
| 17. INFORMANT Mrs. Florence M. Fogle (Same as item #1) | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerosis Hypertension DUE TO (c) 57+ hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 19 30 to Sept. 29 19 59 , that I last saw the deceased alive on Sept. 29 19 59 , and that death occurred at 8:20 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Md. | | | |
| PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. | | | | DATE SIGNED 1 Oct 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-2-59 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 6 '59 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur A. Thomas | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

10232

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|------------------|
| 1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO RURAL | | c. LENGTH OF STAY IN 1b YEARS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO RURAL | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ALICE MICHAEL GEISBERT | | | | 4. DATE OF DEATH Month Day Year SEPT 14 1959 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT 9 - 1893 | 9. AGE (In years lost birthday) yrs. 65 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CHARLES L MICHAEL | | | | 14. MOTHER'S MAIDEN NAME LAURA BROWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 219-36-4244 | | 17. INFORMANT MRS STEINER SMITH | | Address WOODSBORO MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 42a0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiac disease DUE TO (c) 5 yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 10 , 1955, to SEPT. 14 , 1959, that I last saw the deceased alive on SEPT. 8 , 1959, and that death occurred at 5:30 P. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. Franklin Birley M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED Thurmont Md. 9/15/59 | | | |
| PHYSICIAN'S NAME (Type) M. FRANKLIN BIRLEY | | | | THURMONT MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF SEPT 17-1959 | | 22c. NAME OF CEMETERY OR CREMATORY MT HOPE | | 22d. LOCATION (City, town, or county) (State) FREDERICK CO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron E. Haskins ADDRESS New Windsor, Md. | | | | 24a. REC'D BY REGISTRAR DATE SEP 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur & Klaus | |

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File Date: 10/10/1918

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

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PLACE OF REINTERMENT

10214

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 15 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 241 Phebus Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Elmire Naylor Fisher Gray | | 4. DATE OF DEATH Month Day Year 9 17 1959 | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 29-1922 |
| 9. AGE (In years last birthday) 37 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Ollie E. Naylor | | 14. MOTHER'S MAIDEN NAME Mary Viola Ambush | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Mary V. Naylor 11 W. All Saints Street | |
| 17. ADDRESS Fred. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Squamous cell Cancer of esophagus DUE TO (c) 1-year | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 19 Feb., 1959 , to 17 Sept., 1959 , that I last saw the deceased alive on 8 Aug., 1959 , and that death occurred at 1:10 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Robert H. Pilgrum M.D. | | DATE SIGNED Professional Bldg. Frederick, Md. | |
| PHYSICIAN'S NAME (Type) Robert H. Pilgrum | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-21-59 | 22c. NAME OF CEMETERY OR CREMATORY Fairview | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III | | 24a. REC'D BY REGISTRAR SEP 22 '59 | |
| ADDRESS Frederick, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur A. Knaus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1914

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10204

10233

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|-----------------------------------|---|---|--|---|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights | | c. LENGTH OF STAY IN lb 1 Week | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent and Rest Home | | | | d. STREET ADDRESS 19 East Church Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LUCILLE Middle VIRGINIA Last HEFFNER | | | | 4. DATE OF DEATH Month September Day 27 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE Whiten | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 10, 1892 | | 9. AGE (In years last birthday) 67 yrs. | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Clinton Streams | | | | 14. MOTHER'S MAIDEN NAME Sarah Swank | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT Mrs. Anna Edwards-21 West Fourth St., Frederick, | | Address Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 21, 1959 to Sept 27, 1959 , that I last saw the deceased alive on Sept 26, 1959 , and that death occurred at 10:10 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE L. R. Schoolman | | M.D. Louis R. Schoolman, M.D. | | ADDRESS (Street, city or town, state) Professional Building Frederick, Maryland | | DATE SIGNED 9/29/59 | |
| PHYSICIAN'S NAME (Type) Louis R. Schoolman, M.D. | | Frederick, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 1, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland | | | | ADDRESS Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 1 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur E. Klaus | | | |

10332

CERTIFICATE OF DEATH

STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10205

Reg. Dist. No.

10234

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|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buckeystown</u> | | | | c. LENGTH OF STAY IN 1b <u>20 yrs</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS <u>Buckeystown</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ida Marie</u> Middle <u>Hickman</u> Last | | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 29-1881</u> | | 9. AGE (in years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Housekeeper)</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Thomas Hickman</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ida Trundle</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Thomas Hickman, Sterling, Virginia</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12.30 P.M.</u> p. m. | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Buckeystown Frederick, Md</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>B.O. Thomas</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>Sept 26-1959</u> | |
| EXAMINER'S NAME (Type) <u>Dr B.O. Thomas</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 28-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Nelson, Baltimore, Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|-----------------|--|-------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Date of Death | | Place of Death | |
| John (Henderson) | | Male | | 45 | | White | | 1945 | | Home | |
| Residence | | Occupation | | Cause of Death | | Manner of Death | | Time of Death | | Signature of Examiner | |
| 1234 Main St. | | Teacher | | Heart Disease | | Natural | | 10:30 AM | | J. H. Smith | |
| City | | County | | Hospital | | Physician | | Burial Place | | Signature of Coroner | |
| Baltimore | | Anne Arundel | | St. Mary's | | Dr. J. K. Lee | | Catholic Cemetery | | W. B. Jones | |
| State | | Federal | | County | | City | | Street | | Box | |
| Maryland | | United States | | Anne Arundel | | Baltimore | | Main | | 100 | |
| Zip | | Phone | | Telex | | Radio | | Cable | | Other | |
| 21201 | | 555-1234 | | 1234567 | | 1234 | | 1234 | | 1234 | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Effie Middle Celosta Last Hockensmith | | 4. DATE OF DEATH Month Sept. Day 5 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 13, 1879 |
| 9. AGE (In years lost birthday) 80 yrs. | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Stonesifer | | 14. MOTHER'S MAIDEN NAME Emma Jane Byers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs. Loy Hess, Taneytown, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 4yrs (c) Generalized Arteriosclerosis 4-5yrs | | INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compression Fracture of 12th Thoracic Vertebrae | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug , 1955, to Sept 5 , 1959, that I last saw the deceased alive on Sept. 5 , 1959, and that death occurred at 9 P. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. Ambler Thompson M.D. | | ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown Md 9/8/59 | |
| PHYSICIAN'S NAME (Type) E. Ambler Thompson | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/9/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lutheran cemetery | | 22d. LOCATION (City, town, or county) (State) Taneytown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son | | ADDRESS Taneytown, Maryland | |
| 24a. REC'D BY REGISTRAR SEP 9 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. K... | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF MARRIAGE

10232

Married

James Thompson

James Thompson

1912

1912

1912

1912

White

White

White

White

White

White

White

White

White

White

White

White

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10236

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40 | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederic Memorial Hospital | | | | d. STREET ADDRESS 9 Cypress St. x Crescent Drive | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last Hughes | | | | 4. DATE OF DEATH Month September Day 24 Year 19 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 25, 1936 | | 9. AGE (In years last birthday) 23 yrs. | IF UNDER 1 YEAR Months 2 Days 10 Hours 3 Min. 2 | IF UNDER 24 HRS. Hours 3 Min. 2 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman | | 10b. KIND OF BUSINESS OR INDUSTRY Washington Technological Asso. | | 11. BIRTHPLACE (State or foreign country) Maryland N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joe J. Hughes | | | | 14. MOTHER'S MAIDEN NAME Margaret Goodman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-34-0534 | | 17. INFORMANT Charles Rouzer Funeral Home | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO Conditions, if any, which gave rise to immediate cause (b) 816X (c), stating the underlying cause last. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) Head on collision Route 40 # miles w, of Frederick | | | | | |
| 20c. TIME OF INJURY Hour XX Min. 6 p. m. 9/24 19 59 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 | | 20f. (City or town) Route 40 | | (County) Frederic, Md (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B.O. Thomas | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) B.O. Thomas, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/29/1959 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home | | | | ADDRESS Hagerstown, Maryland | | 24a. REC'D BY REGISTRAR DATE SEP 28 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur A. Klaus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|-------------------------------|--|-------------------------------|--|------------------------|--|-----------------------------|--|-------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | |
| John Doe | | 45 | | Male | | White | | 10-15-1918 | |
| Place of Birth | | Residence | | Occupation | | Cause of Death | | Manner of Death | |
| New York City | | 1234 Main St. | | Teacher | | Heart Disease | | Natural | |
| Date of Birth | | Date of Admission to Hospital | | Date of Discharge | | Date of Death | | Date of Burial | |
| 10-1-1883 | | 10-10-18 | | 10-12-18 | | 10-15-18 | | 10-16-18 | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Burial Officer | | Signature of Undertaker | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Name of Medical Examiner | | Name of Coroner | | Name of Registrar | | Name of Burial Officer | | Name of Undertaker | |
| John Doe | | John Doe | | John Doe | | John Doe | | John Doe | |
| Address of Medical Examiner | | Address of Coroner | | Address of Registrar | | Address of Burial Officer | | Address of Undertaker | |
| 1234 Main St. | | 1234 Main St. | | 1234 Main St. | | 1234 Main St. | | 1234 Main St. | |
| City of Medical Examiner | | City of Coroner | | City of Registrar | | City of Burial Officer | | City of Undertaker | |
| Baltimore | | Baltimore | | Baltimore | | Baltimore | | Baltimore | |
| State of Medical Examiner | | State of Coroner | | State of Registrar | | State of Burial Officer | | State of Undertaker | |
| Maryland | | Maryland | | Maryland | | Maryland | | Maryland | |
| County of Medical Examiner | | County of Coroner | | County of Registrar | | County of Burial Officer | | County of Undertaker | |
| Baltimore | | Baltimore | | Baltimore | | Baltimore | | Baltimore | |
| Date of Certificate | | Date of Burial | | Date of Interment | | Date of Cremation | | Date of Disposition | |
| 10-15-18 | | 10-16-18 | | 10-16-18 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10208

10237

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>802 So. Main St</u> | | d. STREET ADDRESS <u>1802 So. Main St</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Maggie Fadella Jones</u> | | 4. DATE OF DEATH Month Day Year <u>September 8 1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>NOV. 20, 1872</u> |
| 9. AGE (In years lost birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Abraham Diehl</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennife Elizabeth Woltz</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| INFORMANT <u>Mrs. Pauline Eyley</u> Address <u>Mt Airy, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>59</u> , that I lost the deceased alive on <u>Sept 8</u> , 19 <u>59</u> , and that death occurred at <u>843</u> p. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D. | | DATE SIGNED <u>9/8/59</u> | |
| PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u> | | <u>Mt Airy, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/11/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u> | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.D. Hartzler</u> ADDRESS <u>Union Bridge Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u> | |

5850

24

CERTIFICATE OF DEATH

10209

Reg. Dist. No.

10215

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK | | c. LENGTH OF STAY IN 1b 27 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MATILDA Middle KETTELS Last | | 4. DATE OF DEATH Month Sept. Day 14 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 16, 1885 |
| 9. AGE (In years lost birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaking | |
| 11. BIRTHPLACE (State or foreign country) Omaha Nebraska | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Ludwig Misrendorf | | 14. MOTHER'S MAIDEN NAME Bertha Bushman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-40-3138 | |
| 17. INFORMANT Durward Kettels | | Address Walkersville Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 hours years. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/ 19 59 to 9/14 19 59 that I last saw the deceased alive on 9/14 19 59 and that death occurred at 6:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/14/59 | | | |
| ACTUAL SIGNATURE Richard C. Reynolds M.D. | | | |
| PHYSICIAN'S NAME (Type) Richard C. Reynolds MD. | | 9 E. Church St. Frederick, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/16/59 | 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE DATTA'S FUNERAL HOME FREDERICK, MARYLAND | | 24a. REC'D BY REGISTRAR DATE SEP 17 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kiana |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10517

PREVIOUS

PREVIOUS

27 yrs

Albionville, Maryland

Postoffice of the Hospital

Frederick, Md.

WHITE

WHITE

Female

July 16, 1955

Married

Housewife

Order 1001-100

Interment

Interment

27-10-1955

Albionville, Maryland

Albionville, Maryland

Dr. Charles G. Gandy
Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10210

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY 10238 Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore 3V01-4 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 340 | | | | d. STREET ADDRESS 1223 Wilcox Street | | | |
| 3. NAME OF DECEASED (Type or print) James R Kincaid | | | | 4. DATE OF DEATH 9 20 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-1-1910 | |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Gilbert Kincaid | | | |
| 14. MOTHER'S MAIDEN NAME Amy | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address Baltimore Mrs. Robert Moon, 1937 East 31st St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Crushed chest, Fractured jaw and nose 825 X DUE TO Automobile Accident Conditions, if any, which gave rise to immediate cause (b) Automobile Accident (c) Automobile Accident (d) Automobile Accident | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident | | | |
| 20c. TIME OF INJURY Month, Day, Year 9-20-59 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 340 | | 20f. (City or town) (County) (State) Petersville, Fred. Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B.O. Thomas | | | | DATE SIGNED 9/20/1959 | | | |
| EXAMINER'S NAME (Type) B.O. Thomas | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-24-59 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. R. Ruck | | | | ADDRESS Baltimore, Maryland | | | |
| 24a. REC'D BY REGISTRAR SEP 23 '59 | | | | 24b. REGISTRAR'S SIGNATURE Charles A. Thomas | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10211

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 2 3401-4</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial</u> | | | | d. STREET ADDRESS <u>1223 Wilcox St</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>C</u> Last <u>Kincaid</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1959</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan 3, 1908</u> | |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Beckley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT Address <u>BALTIMORE</u> <u>MRS ROBERT MEON 1937 E. 31ST ST</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>823X</u> DUE TO <u>Amputation both legs</u> Conditions, if any, which gave rise to immediate cause (b) <u>dislocation both arms</u> (a), stating the underlying cause lost. DUE TO <u>possible fracture of skull</u> (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck Culvert Route 340 Auto turned over</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>9/20/59</u> Hour <u>8:30 PM</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 340</u> | | 20f. (City or town) (County) (State) <u>Patersville Frederick Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>B. G. Thomas</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>B. G. Thomas M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>Sept. 21-1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/24/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>LEONARD J RUCK</u> | | | | ADDRESS <u>5305 HARFORD RD</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 23 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10239

CERTIFICATE OF DEATH

Reg. Dist. No. 10212

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7 | | | | c. LENGTH OF STAY IN 1b Years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7 | | | | d. STREET ADDRESS Edgewood Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edgewood Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle MILTON Last KLINE | | | | 4. DATE OF DEATH Month September Day 13 Year 19 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 July 1893 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months 66 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles D. Kline | | | | 14. MOTHER'S MAIDEN NAME Lola Ann Rebecca Kline | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI | | 16. SOCIAL SECURITY NO. 212-16-2852 | | INFORMANT Albert H. Smith Address 1042 Security Road Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis 421.1 DUE TO Cardial Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5Yrs 5Yrs 8Yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 50 , to Sept 13 , 19 59 , that I last saw the deceased alive on Sept 11 , 19 59 , and that death occurred at 9 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | ADDRESS (Street, city or town, state) 228 N. Market Street DATE SIGNED 15 Sept 59 | | | |
| PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. | | | | Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 17 Sep 59 | | 22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery | | 22d. LOCATION (City, town, or county) (State) Rocky Springs Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE SEP 22 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur A. Hager | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Two for One. FilmG249 9-24-59 et

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours of death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10213

10224

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. LENGTH OF STAY IN 1b 50 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 West "J" Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Polly Middle - Last Lipscomb | | 4. DATE OF DEATH Month 9-6- Day 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-4-1877 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. | 11. IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Willis Whitten | | 14. MOTHER'S MAIDEN NAME (Unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Harry L. Lipscomb, Brunswick, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensated congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 7 , 19 57 , to Sept. 6 , 19 59 , that I last saw the deceased alive on Sept. 6 , 19 59 , and that death occurred at 11:20 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 So. Maryland Ave. Md. 9-7-59 DATE SIGNED | | | |
| ACTUAL SIGNATURE C. T. Byron Kao, M.D. | | PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. Brunswick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-9-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lucketts | | 22d. LOCATION (City, town, or county) (State) Lucketts, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. L. Feste | | ADDRESS Brunswick, Maryland | |
| 24a. REC'D BY REGISTRAR DATE SEP 10 '59 | | 24b. REGISTRAR'S SIGNATURE C. L. Feste | |

CERTIFICATE OF DEATH

1934

23

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

10217

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 17 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Miller Last Longbrake | | 4. DATE OF DEATH Month 9 Day 10 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-10-1887 |
| 9. AGE (In years lost birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months 72 Days 10 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hostler | | 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Longbrake | | 14. MOTHER'S MAIDEN NAME Dallis Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Informant | |
| 17. ADDRESS Mrs. Gertrude L. Goodwin, Arlington, Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Paraplegia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | INTERVAL BETWEEN ONSET AND DEATH 13 yrs. 5 mos | |
| 21. I certify that I attended the deceased from 1954 to Sept. 10, 1959 , that I last saw the deceased alive on Sept. 1, 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ACTUAL SIGNATURE H. K. Kline | | ADDRESS (Street, city or town, state) 711 Market St. Frederick, Md. | |
| PHYSICIAN'S NAME (Type) H. K. Kline M.D. | | DATE SIGNED Frederick Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-13-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Marks | | 22d. LOCATION (City, town, or county) (State) Petersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt | | 24a. REC'D BY REGISTRAR DATE SEP 14 '59 | |
| ADDRESS Brunswick, Maryland | | 24b. REGISTRAR'S SIGNATURE C. C. Kline | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

10225

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| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. LENGTH OF STAY IN 1b 26 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 924 East "C" Street | | d. STREET ADDRESS 924 East "C" Street | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle C. Last Lynch | | 4. DATE OF DEATH Month 9 Day 22 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-20-1906 |
| 9. AGE (In years last birthday) yrs. 53 | | 10. IF UNDER 1 YEAR Months 5 Days 3 Hours 15 Min. 53 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad Washington | |
| 11. BIRTHPLACE (State or foreign country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UN KNOWN | | 14. MOTHER'S MAIDEN NAME UN KNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Flora Lynch, Brunswick, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiovascular thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 5 min. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 10 , 19 58 , to Sep. 22 , 19 59 , that I last saw the deceased alive on Sep. 22 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. T. Kao | | DATE SIGNED 15 So. Maryland Ave. 9-23-59 | |
| PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D. | | Brunswick, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-25-59 | 22c. NAME OF CEMETERY OR CREMATORY Park Heights | 22d. LOCATION (City, town, or county) (State) Brunswick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Les Fecto | | 24a. REC'D BY REGISTRAR SEP 24 59 | |
| ADDRESS Brunswick, Maryland | | 24b. REGISTRAR'S SIGNATURE Wm. E. Fennell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10825

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1



10240

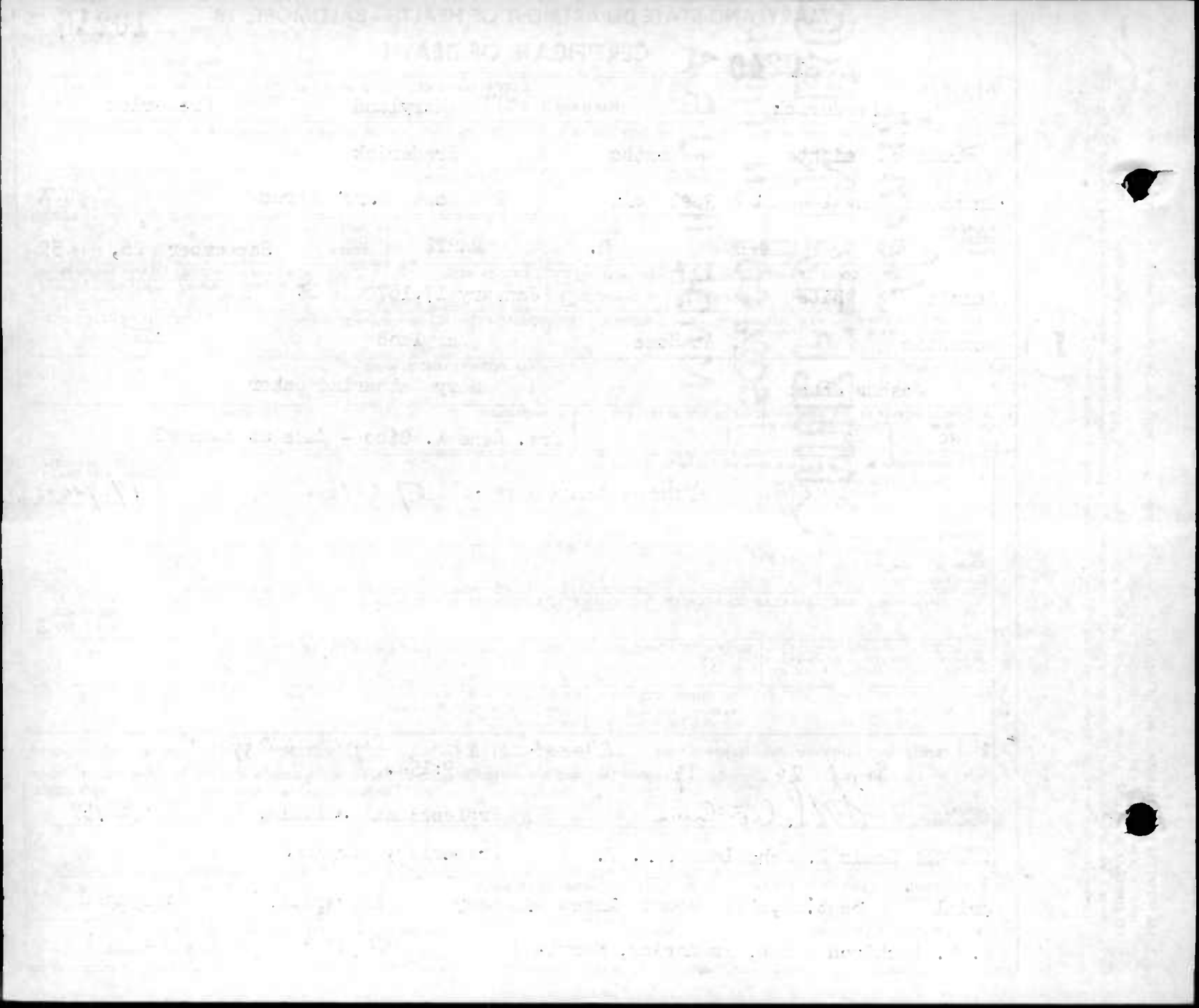
CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights | | | | c. LENGTH OF STAY IN 1b Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent & Rest Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle R. Last MARTZ | | | | 4. DATE OF DEATH Month September Day 26 Year 1959 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 17, 1870 | |
| 9. AGE (In years at birthday) 89 yrs. | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Joshua James | | | | 14. MOTHER'S MAIDEN NAME Mary Catherine Baker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No | | | |
| 17. INFORMANT Mrs. Rene X. Gibo - Same as Item #2 | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March, 1958 to September 26, 1959 , that I last saw the deceased alive on Sept 26, 1959 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 9/28/59 | | | |
| PHYSICIAN'S NAME (Type) Louis R. Schoolman, M.D. | | | | Frederick, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 29, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS Frederick, Maryland | | 24a. REC'D BY REGISTRAR OCT 1 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10217

Reg. Dist. No.

| | | | | | | | | | | | | | | | |
|--|---|---|---|--|---|--------------|--|---|----------------|-------------------------------------|--|--------------|--|------------|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy d. STREET ADDRESS R.D. 4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JOHN MCKINLEY MERCER First Middle Last | | 4. DATE OF DEATH Month SEPT. Day 25 Year 19 59 | | | | | | | | | | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 29, 1896 | | | | | | | | | | | | |
| 9. AGE (In years last birthday) 63 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY owner 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | | | | |
| 13. FATHER'S NAME Charles E. Mercer | | 14. MOTHER'S MAIDEN NAME Lavinia Poole | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) yes W.W. 1 | | 16. SOCIAL SECURITY NO. 214-22-0854 17. INFORMANT John D. Mercer, Unionville, Md. Address | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X </td> <td style="width: 70%;"> INTERVAL BETWEEN ONSET AND DEATH 10 Min. </td> </tr> <tr> <td> DU TO </td> <td> </td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> 5 yrs.- </td> </tr> <tr> <td> (b) Diabetes Mellitus </td> <td> </td> </tr> <tr> <td> DU TO </td> <td> </td> </tr> <tr> <td> (c) </td> <td> </td> </tr> </table> | | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X | INTERVAL BETWEEN ONSET AND DEATH 10 Min. | DU TO | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | 5 yrs.- | (b) Diabetes Mellitus | | DU TO | | (c) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260X | INTERVAL BETWEEN ONSET AND DEATH 10 Min. | | | | | | | | | | | | | | |
| DU TO | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | 5 yrs.- | | | | | | | | | | | | | | |
| (b) Diabetes Mellitus | | | | | | | | | | | | | | | |
| DU TO | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>B. O. Thomas</i> M.D. EXAMINER'S NAME (Type) B. O. THOMAS | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-25-1959 | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 9-29-1959 | 22c. NAME OF CEMETERY OR CREMATORY Pine Grove | 22d. LOCATION (City, town, or county) Mt. Airy, Md. (State) | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 30 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hines</i> | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—Baltimore, Md.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Figure 1. The effect of the concentration of the polymer on the α -transition temperature of the polymer.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10218
CERTIFICATE OF DEATH

10218

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | d. STREET ADDRESS 110 Monroe Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LOIS Middle JACQUELINE Last MILLER | | | | 4. DATE OF DEATH Month September Day 14 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 20 April 1927 | | 9. AGE (In years last birthday) 32 yrs. | IF UNDER 1 YEAR Months 3 Days 14 Hours 14 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Frederick Tool & Engineer Corp. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Eugene M. Kemp | | | | 14. MOTHER'S MAIDEN NAME Dovie Irene Harshman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-22-9518 | | 17. INFORMANT Mr. Eugene M. Kemp Address (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmatus 241X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Acute Cardiac Failure DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 1/2 hr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 12, 1959 to Sept. 14, 1959 , that I last saw the deceased alive on Sept. 14, 1959 , and that death occurred at 3:50 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Md. DATE SIGNED 16 Sept 1959 ACTUAL SIGNATURE B. O. Thomas PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-18-59 | | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE SEP 17 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

1
Page 4
death. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10219

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital | | d. STREET ADDRESS Main St. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clara O. Nail | | 4. DATE OF DEATH Month Day Year Sep 9 1959 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-17-1891 |
| 9. AGE (In years last birthday) yrs. 68 | | IF UNDER 1 YEAR Months Days Hours Min. 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Thomas Wetzel | | 14. MOTHER'S MAIDEN NAME Mary E. Dayhoff | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Elsie M. Duvall, | | Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 5 yr + | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/8 , 19 59 , to 9/9 , 19 59 , that I last saw the deceased alive on 9/9 , 19 59 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry V. Chase M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 4 E. Church St 9/9/59 | |
| PHYSICIAN'S NAME (Type) Henry V. Chase | | Frederick Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 9-12-1959 | 22c. NAME OF CEMETERY OR CREMATORY Pine Grove | 22d. LOCATION (City, town, or county) (State) Mt. Airy, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Md. | |
| 24a. REC'D BY REGISTRAR DATE SEP 14 '59 | | 24b. REGISTRAR'S SIGNATURE Orthur & Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

| | | | |
|---|--|---|--|
| <p>NAME OF DECEASED Thomas M. Davis</p> | | <p>RESIDENCE 1212 N. E. Street</p> | |
| <p>DATE OF DEATH April 1, 1912</p> | | <p>PLACE OF DEATH Home</p> | |
| <p>AGE 45</p> | | <p>SEX Male</p> | |
| <p>CAUSE OF DEATH Heart Disease</p> | | <p>IMMEDIATE CAUSE Myocardial Infarction</p> | |
| <p>DATE OF BIRTH March 1, 1867</p> | | <p>PLACE OF BIRTH Virginia</p> | |
| <p>EDUCATION High School</p> | | <p>OCCUPATION Teacher</p> | |
| <p>RELIGION Methodist</p> | | <p>PREVIOUS ILLNESS None</p> | |
| <p>DATE OF INTERMENT April 3, 1912</p> | | <p>PLACE OF INTERMENT Greenwood Cemetery</p> | |
| <p>SIGNATURE OF DECEASED <i>Thomas M. Davis</i></p> | | <p>SIGNATURE OF WITNESSES <i>John M. Davis, Mary M. Davis</i></p> | |
| <p>DATE OF SIGNATURE April 1, 1912</p> | | <p>PLACE OF SIGNATURE Home</p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10220

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY 10242 Frederick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown | | c. LENGTH OF STAY IN 1b Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) MERHL T. O'HARA | | | 4. DATE OF DEATH Month September Day 4 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH February 2, 1891 | | 9. AGE (In years last birthday) 68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John O'Hara | | | 14. MOTHER'S MAIDEN NAME Mollie L. Bear | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Mr. William H. O'Hara 423 South Market Street Frederick, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH Minutes</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) B. O. Thomas, MD. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 7, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Bush Creek Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State) Monrovia, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | 24a. REC'D BY REGISTRAR DATE SEP 9 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline |

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

10220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 93 West Main Street 0627-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Frederick Memorial Hospital | | | d. STREET ADDRESS Westminister | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle CHURCH Last PLUSH | | | 4. DATE OF DEATH Month September Day 21 Year 19 59 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2 Dec 1882 | | 9. AGE (In years last birthday) 76 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Wisconsin | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME William H. Plush | | | 14. MOTHER'S MAIDEN NAME Mary Miers | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Lewis M. Esworthy, 154 S. Green St., Westminister, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension and Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 Hours 5 Years-Plus |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE B O Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) B. O. Thomas, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 21 Sept 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-23-59 | 22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | 22d. LOCATION (City, town, or county) (State) Middletown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | 24a. REC'D BY REGISTRAR DATE SEP 24 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Charles A. King</i> |

STATE
DEPT.

10320

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

GENERAL RECORDING AND INDEXING
OFFICE

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | | c. LENGTH OF STAY IN 1b 50 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Powell | | 4. DATE OF DEATH Month Sept. Day 12 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 11, 1885 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73 | 11. IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Thurmont, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Daniel Shook | | 14. MOTHER'S MAIDEN NAME Mattie Norton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Curbis N. Powell | |
| 17. INFORMANT Curbis N. Powell | | Address Thurmont, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 170X DUE TO (c) 170X | | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 4 , 19 59 , to Sept. 12 , 19 59 , that I last saw the deceased alive on Sept. 12 , 19 59 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James K. Gray | | ADDRESS (Street, city or town, state) Thurmont MD | |
| PHYSICIAN'S NAME (Type) James K. Gray | | DATE SIGNED 9-14-1959 | |
| 22a. BURIAL, CREMATION, REBURY (Specify) Burial | 22b. DATE THEREOF 9-15-59 | 22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | 22d. LOCATION (City, town, or county) (State) Thurmont, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | ADDRESS Thurmont, Md. | |
| 24a. REC'D BY REGISTRAR DATE SEP 17 '59 | | 24b. REGISTRAR'S SIGNATURE Curbis N. Powell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Frederick

Maryland

Frederick

Thurmont

50 yrs.

Thurmont

Greenhouse Rd.

Own home

52

Sept. 19

Catherine Powell

Wife

73

Nov. 11, 1885

X

White

Female

U.S.A.

Thurmont, Md.

Own home

Residence

Mattie Norton

Deaf and dumb

Curtis A. Powell, Thurmont, Md.

No

9-18-1959

Thurmont MD

James E. Gray

Thurmont, Maryland

Blue Ridge Cemetery

9-18-59

Thurmont, Md.

Raymond E. Greaser

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LOTTIE Middle ELEANOR Last REMSBURG | | 4. DATE OF DEATH Month September Day 13 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 17 Dec 1909 |
| 9. AGE (In years last birthday) 49 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 13 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wesley Swope | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Melvin R. Smith, Gaithersburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of heart and lungs 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of left breast DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 y 4 y | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 12 , 19 57 , to Sept 15 , 19 59 , that I last saw the deceased alive on Sept 13 , 19 59 , and that death occurred at 6:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Shopping Center DATE SIGNED 15 Sept 1959 | | | |
| ACTUAL SIGNATURE Ralph L. Michels | | M.D. Frederick, Md. | |
| PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D. | | Frederick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-16-59 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE SEP 16 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

WYOMING

NEW YORK

NEW YORK

NEW YORK

WYOMING

WYOMING & NEW YORK

WYOMING

1934

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

10245

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown | | c. LENGTH OF STAY IN lb Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILBUR Middle HOMER Last RENN | | 4. DATE OF DEATH Month September Day 13 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1 Jan 1894 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | |
| 11. BIRTHPLACE (State or foreign country) Adamstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William H. Renn | | 14. MOTHER'S MAIDEN NAME Edith G. Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-36-7251 | |
| 17. INFORMANT Mrs. Beatrice S. Renn (Same as item #1) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma of rt. Kidney DUE TO (b) with pulmonary metastases Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1957 , 19 13 Sept , 19 59 , that I last saw the deceased alive on 12 Sept , 19 59 , and that death occurred at 5:35 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Md. DATE SIGNED 15 Sept 1959 | | | |
| ACTUAL SIGNATURE Charles H. Conley, Jr. M.D. | | PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-16-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DATE SEP 16 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

DATE

AGE

RESIDENCE

SEX

RACE

EDUCATION

RELIGION

CAUSE

MANNER

PLACE

TIME

TEMPERATURE

PULSE

BLOOD PRESSURE

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

REMARKS

1-10-1902

Handwritten signature and notes

1-10-1902

1-10-1902

1-10-1902

1-10-1902

1-10-1902

1-10-1902

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1-10-1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225

10246

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | c. LENGTH OF STAY IN 1b <u>2 YEARS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>E</u> Last <u>SIX</u> | | 4. DATE OF DEATH Month <u>SEPT</u> Day <u>18</u> Year <u>1959</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 31-1866</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER AT HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>WILLIAM H BLIZZARD</u> | | 14. MOTHER'S MAIDEN NAME <u>SUSAN (UNKNOWN)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>L.N. BAKER</u> | | Address <u>UNION BRIDGE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Nov 8, 1958</u> , to <u>Sept 18, 1959</u> , that I last saw the deceased alive on <u>Sept 17, 1959</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. N. Dege</u> | | ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> | |
| PHYSICIAN'S NAME (Type) <u>T. H. LIEGG MD</u> | | DATE SIGNED <u>9-18-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>9/21/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u> | 22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Bartlett</u> | | 24a. REC'D BY REGISTRAR <u>Charles R. Kinn</u> | |
| ADDRESS <u>Union Bridge MD</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles R. Kinn</u> | |
| DATE <u>SEP 22 '59</u> | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

10247

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 5, Frederick | | c. LENGTH OF STAY IN 1b Lifelong | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 5, Frederick, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle REBECCA Last SMITH | | 4. DATE OF DEATH Month September Day 2 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 2, 1891 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaker | |
| 11. BIRTHPLACE (State or foreign country) Frederick County Md. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Granville C. Zimmerman | | 14. MOTHER'S MAIDEN NAME Emma V. Harris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-01-2920 | |
| 17. INFORMANT Wilbert L. Smith, Rt. # 5, Frederick, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) Generalized Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 30, 1959 , to Sept 2, 1959 , that I last saw the deceased alive on Sept 2, 1959 , and that death occurred at M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Elmer Harp | | ADDRESS (Street, city or town, state) Middletown | |
| PHYSICIAN'S NAME (Type) J. ELMER HARP, M.D. | | DATE SIGNED 9-3-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/5/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Zion Reformed Cemetery | | 22d. LOCATION (City, town, or county) (State) Charlesville Md. | |
| 23. FUNERAL HOME DRURY'S FUNERAL HOME | | 24a. REC'D BY REGISTRAR FREDERICK, MD. | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | DATE SEP 10 '59 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

MASSACHUSETTS

WILLIAM

Age 75, male, white, married, born in Massachusetts, died of natural causes.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

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Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

Dec. 15, 1934, at his home, 123 Main St., Boston, Mass.

10221

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Since-1924 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 Rockwell Terrace | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RUTHERFORD Middle DEAN Last STICKELL | | | | 4. DATE OF DEATH Month September Day 19 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1 Jan 1898 | |
| 9. AGE (In years last birthday) 61 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | | 11. IF UNDER 24 HRS. Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Chiropractor | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME John H. Stickell | | | | 14. MOTHER'S MAIDEN NAME Anna Hartman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 220-26-5169 | | | |
| 17. INFORMANT Mrs. Helen M. Stickell | | | | Address (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Intermittent heart disease with acute myocardial infarction DUE TO (b) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years over 12 yrs | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 5-10- 19 27 , to 8-21 19 57 , that I last saw the deceased alive on 8-21 19 57 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 N. Market St. Frederick, Md. DATE SIGNED 19 Sept 1959 | | | | | | | |
| ACTUAL SIGNATURE Rex R. Martin M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 9-21-59 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | | | | |
| ADDRESS | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE SEP 21 '59 | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur E. Kline | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1982

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

10248

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|---|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle BELLE Last STOCKMAN | | | | 4. DATE OF DEATH Month September Day 16 Year 19 59 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4 Feb 1871 | |
| 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph E. Zimmerman | | | | 14. MOTHER'S MAIDEN NAME Mahala Catherine Stine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | | INFORMANT Address Mrs. Ruth S. Ingram (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Advanced Generalized Arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 5 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 2, 1959 to Sept 16, 1959 that I last saw the deceased alive on Sept 16, 1959 and that death occurred at 10:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jefferson, Md. 18 Sept 1959 | | | | | | | |
| ACTUAL SIGNATURE A. T. Brice M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) A. T. Brice, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-19-59 | | 22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery | | 22d. LOCATION (City, town, or county) (State) Feagville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE SEP 21 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

10226

| | | | | | |
|--|---|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Federick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | | c. LENGTH OF STAY IN 1b 39 yrs. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 332 West Potomac Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clarence Elvin Streight | | | 4. DATE OF DEATH Month Day Year 9 16 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-16-1896 | | 9. AGE (In years last birthday) yrs. 63 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Helper | | 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co. | | 11. BIRTHPLACE (State or foreign country) Penn. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME John Streight | | |
| 14. MOTHER'S MAIDEN NAME Rosie Bussard | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War 1 | | |
| 16. SOCIAL SECURITY NO. 420.1 | | | 17. INFORMANT Address Mrs. Willma Streight, Brunswick, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure DUE TO (c) pulmonary emphysema | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 min. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from May 9, 1959 to Sept. 16, 1959 , that I last saw the deceased alive on Sept. 16, 1959 , and that death occurred at 7:30 PM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | ADDRESS (Street, city or town, state) 15 So. Maryland Ave. Brunswick, Maryland | | DATE SIGNED 9-17-59 | |
| PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-19-59 | 22c. NAME OF CEMETERY OR CREMATORY Park Heights | | 22d. LOCATION (City, town, or county) (State) Brunswick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE SEP 22 '59 | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10328



10328

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10230

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick 10222 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1637 W. North Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Lillian</i> Middle <i>Thomas</i> Last 4. DATE OF DEATH <i>Sept.</i> Month <i>24</i> Day <i>1959</i> Year | | 5. SEX F 6. COLOR OR RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>9/27/23</i> 9. AGE (In years last birthday) <i>36</i> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Lloyd Thomas 14. MOTHER'S MAIDEN NAME Dorothea Bogle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Frederick Thomas Address 351A Suter Ave. 28 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO 816x Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision Route 40 20c. TIME OF INJURY Month, Day, Year <i>9/24/59</i> Hour <i>6</i> a. <input checked="" type="checkbox"/> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 20f. (City or town) Nr. Frederick (County) Frederick (State) Md. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>B.O. Thomas</i> EXAMINER'S NAME (Type) B.O. Thomas, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 24, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-30-59 22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem 22d. LOCATION (City, town, or county) Baltimore- (State) Md. | | 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Steadley</i> ADDRESS 578 W. Biddle St. 24a. REC'D BY REGISTRAR SEP 28 '59 24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

• 374-4370 • 375-7200 •

[Faint, illegible text]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10231

Reg. Dist. No.

10249

| | | | | | | | |
|--|------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Frederick Route 40 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS 1637 North Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Ernestine Last Tillman | | | | 4. DATE OF DEATH Month September Day 24 Year 1959 | | | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 5, 1921 | | 9. AGE (In years last birthday) 38 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Will Douglas | | | | 14. MOTHER'S MAIDEN NAME Lillian Daymon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-38-5827 | | 17. INFORMANT Lillian Daymon Address 722 North Main St. Tamper 7, Florida | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 816X DUE TO Laceration Right Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Minutes</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision Route 40 3 miles West of Frederick | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 9/24/59 Hour 6 a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 | | 20f. (City or town) (County) (State) West of Frederick Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B. O. Thomas | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) B. O. Thomas, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 25, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF Sept 26, 59 | | 22c. NAME OF CEMETERY OR CREMATORY Memorial Park | | 22d. LOCATION (City, town, or county) (State) Tamper, Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | | | ADDRESS 1808 N. Monroe St. | | 24a. REC'D BY REGISTRAR SEP 29 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10232

10250

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40 | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS 316 N. Locust | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Franklin Last Trenery | | | | 4. DATE OF DEATH Month September Day 24 Year 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 26, 1921 | | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov. | | 11. BIRTHPLACE (State or foreign country) Hagerstown Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gibson S. Trenery | | | | 14. MOTHER'S MAIDEN NAME Lessie Carrico | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W. W. 11 219-14-8053 | | 17. INFORMANT Mrs. Gertrude V. Trenery | | Address Hag. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision Route 40, 3 miles W. Frederick | | | | | |
| 20c. TIME OF INJURY Hour 6 p. m. Month, Day, Year 9/24 59 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 | | 20f. (City or town) (County) (State) Nr. Frederick Frederick Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE B.O. Thomas | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) B.O. Thomas, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 9/25/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-27-59 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son | | | | ADDRESS Hagerstown Md. | | 24a. REC'D BY REGISTRAR SEP 28 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Carlton & Kline | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

10251

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | | c. LENGTH OF STAY IN 1b 6 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Emma Middle Esther Last Whitmore | | 4. DATE OF DEATH Month Sept. Day 7 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 19, 1893 |
| 9. AGE (In years last birthday) yrs. 66 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles W. Recard | | 14. MOTHER'S MAIDEN NAME Sally Bare | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 312-38-9405 | |
| 17. INFORMANT Mrs. Evelyn Powell | | Address Thurmont, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, acute. 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Diabetes mellitus. DUE TO (c) Cerebrovascular accident, old | | | INTERVAL BETWEEN ONSET AND DEATH 1-2 days. 8-9 mos. 8-9 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 26 July 19 57 to 7 Sept 19 59 that I last saw the deceased alive on 5 Sept. 19 59 , and that death occurred at 9:00 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Harry H. Youngs, Jr. | | ADDRESS (Street, city or town, state) DATE SIGNED Blue Ridge Summit Pa. Sept. 8. 59 | |
| PHYSICIAN'S NAME (Type) Harry H. Youngs, Jr. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-9-59 | 22c. NAME OF CEMETERY OR CREMATORY United Brethren Cem. | 22d. LOCATION (City, town, or county) (State) Thurmont, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | 24a. REC'D BY REGISTRAR DATE SEP 10 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline |

1

Page 4

death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1921

Frederick

Maryland

Frederick

Thurmont

6 yrs.

Thurmont

Sept. 7

Whitmore

Bath

James

66

May 19, 1893

xx

Female White

U.S.A.

Penna.

own home

housewife

Billy Bare

Charles W. record

Thurmont, Md.

Mrs. Evelyn Powell

No

Thurmont, Maryland

United Brothers Cem.

9-9-20

Funeral

Thurmont, Md.

Raymond J. Greaser

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10223

CERTIFICATE OF DEATH

Reg. Dist. No.

10234

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b X Knoxville Brunswick R.D.#1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle CLAUDE Last WILES | | 4. DATE OF DEATH Month September Day 26 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 13, 1894 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William T. Wiles | | 14. MOTHER'S MAIDEN NAME Margaret Jane Mullican | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 705-12-1724 | |
| 17. INFORMANT Mrs. Elsie E. Wiles-Same as Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, massive 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease DUE TO (c) 3-4 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/26 , 19 59 , to 9/26 , 19 59 , that I last saw the deceased alive on 9/26 , 19 59 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street DATE SIGNED 9/29/59 | | | |
| ACTUAL SIGNATURE Henry V. Chase | | M.D. Frederick, Maryland | |
| PHYSICIAN'S NAME (Type) Henry V. Chase, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 30, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | ADDRESS | |
| 24a. REC'D BY REGISTRAR DATE OCT 1 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thoms | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10523

CERTIFICATE OF DEATH

10523

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

DECEASED AT HOME OF _____
RESIDENT OF _____
CITY OF _____
COUNTY OF _____
STATE OF _____
DECEASED AT _____
RESIDENT OF _____
CITY OF _____
COUNTY OF _____
STATE OF _____

CAUSE OF DEATH

DATE OF DEATH

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

DECEASED AT _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10235

10252

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | | c. LENGTH OF STAY IN 1b 50 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, Maryland | | d. STREET ADDRESS E. Main St. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Sarepta Middle Grimes Last Winger | | 4. DATE OF DEATH Month Sept. Day 10 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 7, 1875 |
| 9. AGE (In years lost (thday) yrs.) 84 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Garner T. Grimes | | 14. MOTHER'S MAIDEN NAME Sarah E. Hesson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| INFORMANT Warner T. Grimes | | Address Thurmont, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scirrus Carcinoma, gastric 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 15 , 19 59 , to Sept. 9 , 19 59 , that I lost saw the deceased alive on Sept. 9 , 19 59 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James K. Gray | | ADDRESS (Street, city or town, state) Thurmont, Md. | |
| PHYSICIAN'S NAME (Type) James K. Gray | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-12-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY United Brethren Cem. | | 22d. LOCATION (City, town, or county) (State) Thurmont, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | ADDRESS Thurmont, Md. | |
| 24a. REC'D BY REGISTRAR DATE SEP 14 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

CERTIFICATE OF DEATH

1925

| | | | | | | | |
|------------------|---------------------|--------------------|--------------------|-----------------|-----------------|-----------------|-----------------|
| Frederick | Maryland | Thurmont, Maryland | 50 yrs. | Own Home | Sept. 10 | Sept. 10 | U.S.A. |
| Female - White | Grimes | Winger | Aug. 7, 1875 | Own Home | U.S.A. | Garth E. Hesson | Garth E. Hesson |
| Walter T. Grimes | None | Walter T. Grimes | Thurmont, Maryland | Garth E. Hesson | Garth E. Hesson | Garth E. Hesson | Garth E. Hesson |
| James L. Gray | United Brethren Ch. | Thurmont, Maryland | Thurmont, Md. | Thurmont, Md. | Thurmont, Md. | Thurmont, Md. | Thurmont, Md. |